LOUISIANA

Department of HEALTH and HOSPITALS

OFFICE OF LOUISIANA Department of HEALTH and HOSPITALS AGING AND ADULT SERVICES

PACE

Technical

Assistance

Guide

Prepared in response to HCR 141of the 2009 regular legislative session, January 12, 2010

PACE Technical Assistance Guide

DHH Office of Aging and Adult Services

Program of All-Inclusive Care for the Elderly (PACE)

PACE programs coordinate and provide all needed preventive, primary, acute and long term care services so that older individuals can continue living in the community.

Eligibility:

Participants are person's age 55 years old or older, live in the PACE provider service area and certified by the state to need nursing home care. Participation in PACE is strictly voluntary and enrollees may disenroll at any time. In order to qualify for Medicaid, an individual's income cannot be higher than 300% of the Supplemental Security Income per month and total resources must meet Medicaid guidelines. Many variables apply when determining financial eligibility, income limits are different when an individual is married and amounts are subject to change.

According to the National PACE Association, most PACE participants live alone in the community, are women and are over 80 years old.

Services:

PACE programs are required to provide (directly or through a network of contracted providers) all Medicare and Medicaid services. These include but are not limited to physician services, hospital care and a variety of long term care services, including nursing home services, if needed. The emphasis is on enabling participants to remain in their community and enhancing quality of life. Participants are transported to and from the PACE center to receive services. Basic services like adult day health care services, physician services, occupational therapies, and primary medical care are generally provided on-site at the PACE center.

Required Services:
Primary care
Social work
Restorative therapies
Personal care/Supportive services

Nutritional counseling
Prosthetics, orthotics, DME, corrective
Vision, devices, hearing aids, dentures,
Repair and maintenance of these items
Other services determined necessary to
Improve or maintain the participant's
overall health status

Recreational therapy
Transportation
Meals
Medical specialty services
Laboratory tests, x-rays & diagnostic procedures
Drugs & biologicals
Acute inpatient care
Nursing facility care

Payment:

PACE is reimbursed similar to a managed health care plan. Both Medicare and Medicaid reimburse PACE a capitated per member per month payment. The current Medicaid reimbursement is based on the average that what would have been paid to serve the same population under the fee-for-service system. Most participants are dually eligible for Medicare and Medicaid. Those who are ineligible for Medicaid can choose to join PACE by paying the Medicaid monthly portion as a premium. Some individuals who are ineligible for Medicaid may have a long term care insurance policy that would provide coverage for the benefits. Medicare and Medicaid do not pay any other provider for services for an enrollee when PACE is chosen. The PACE provider does not file claims with the state, instead the provider is paid the capitated payment each month. The PACE provider is *at full risk*; meaning that the provider is responsible for any care costs which exceed the monthly capitated payment for any enrollee.

Characteristics of a PACE Provider:

Per federal regulation, PACE providers are not-for-profit organizations that bear financial risk for all medical and support services required for enrollees. Each PACE site serves a specific geographic area. PACE sites typically serve about 200 enrollees.

Regulatory Authority

PACE was established as a Medicaid State Plan service by the federal Balanced Budget Act of 1997 (BBA '97). Federal regulations are promulgated at 42CFR460. Prior to BBA '97, individual PACE programs were established as demonstration projects.

Based on the CMS regulations, PACE is different from any other Medicaid service in that each PACE provider must submit a provider application to CMS. Once the provider application is approved, a three-way program agreement is executed between the state administering agency (DHH), CMS and the PACE provider. Only then may the PACE provider begin serving people in the geographic area in which they operate and being paid the capitated rate for those enrollees.

History of PACE

PACE was created in 1971 in San Francisco as an initiative to help the Asian-American community care for its elders in their homes. For these families, the option of placing frail older family members in a nursing home was not a culturally acceptable solution. In order to meet this community need, On Lok Senior Services ("On Lok" is Cantonese for "peaceful happy abode") created an innovative way to offer a comprehensive array of medical supervision, physical and occupational therapies, nutrition, transportation, respite care, socialization and other needed services using home care and an adult day setting. On Lok led to a Robert Wood Johnson grant, and to the demonstration programs which served as the basis for the current Medicaid service.

Current Status of PACE

There are currently 48 PACE programs operating in 22 states. There are four states currently developing PACE programs and 8 states considering adding PACE to its long term care system.

PACE Greater New Orleans, sponsored by Catholic Charities opened its doors in September 2007. The Franciscan Missionaries of Our Lady Health System (FMOLHS) has opened a PACE program in the Baton Rouge area in July, 2008. The Franciscan Missionaries of Our Lady Health System (FMOLHS) has been awarded the right to open a PACE program in the Monroe area, but that site is pending the availability of funding.

Becoming a PACE Provider

Becoming a PACE provider is no easy task and prospective providers must be committed to the program in order to survive the process. In order to become a PACE provider, an organization must be chosen by the state. Once the state designates the area to be served by PACE, it releases a Request for Information (Appendix 1). This is an informal process in which the provider has an opportunity to learn about PACE and the state has an opportunity to learn about interested potential providers. The state selects a provider/organization with which to work and ultimately that organization may become the PACE provider.

PACE Capitalization Requirements

The PACE development process can (and usually does) take between 18 months and 2 years before the provider begins serving participants and receiving capitated payments for enrolled participants. It has been said that it can take between $2 – 4 million to capitalize a PACE program. This process is long and expensive because prior to serving the first person, the PACE organization is determining how it will provide all necessary care and services for the individuals that enroll in PACE services (see links for additional information).

PACE programs must have an adult day health care center, a primary care clinic in which a physician treats patients and a therapy center/area in which physical and occupational therapy take place. This is where the participants see their primary care physician as well as receive these other services. A building must be capitalized and built or retrofitted for this purpose during the start up period.

Also during this time, staff must be hired and a provider network must be developed in which all Medicare and Medicaid services included in the state plan will be provided. Since PACE works as a managed care plan, PACE must have a provider network to serve participants when they need services not provided directly by the PACE provider. PACE is fully at risk for participants' care at all times, so provisions must be made to care for them when they are ill. PACE explains this in the Provider Application that is submitted to the state and CMS. However, the goal is to keep participants as healthy as possible at all times.

PACE is primarily regulated by the federal Centers for Medicare and Medicaid. LA has added few regulations, primarily that the adult day health center (ADHC) component of PACE must be licensed as an (ADHC). There is no PACE license. When PACE is ready and has obtained the ADHC license, the state conducts a Readiness Review. Once all preliminary requirements are complete and the provider is ready to begin serving participants, CMS, the state and the PACE provider sign the CMS Provider Agreement (See links). Once the CMS Provider Agreement has been fully executed, the provider may begin serving enrolled participants.

Resources

Centers for Medicare & Medicaid - PACE page http://www.cms.hhs.gov/PACE/

National PACE Association - NPA offers numerous resources and tools for providers to understand the PACE model, assess their organization's commitment and capacity, assess their community's needs, and move forward with development or expansion of a PACE program. www.NPAonline.org

Publications/Documents

- CMS Federal Rules – 1999 PACE Regulation, PACE Interim Final Rule, Final Regulation

  http://www.cms.hhs.gov/PACE/03_Regulation&Background.asp#TopOfPage

- Provider Application and Appendices, Program Agreement

  http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp#TopOfPage

- Business Planning Checklist for New PACE Programs - http://www.npaonline.org/website/download.asp?id=753

Appendix

Appendix 1. SAMPLE

Request for Information

For

Program of All-Inclusive Care for the Elderly

State of Louisiana

Department of Health and Hospitals

Office of Aging and Adult Services

Tuesday, September 13, 2007

SAMPLE

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PART III. RESPONSES

SAMPLE

I. GENERAL INFORMATION

A. Background

Governor Kathleen Babineaux Blanco's Executive Order No. KBB 2004-43, Louisiana's Plan for Choice in Long Term Care, directed that a Plan for Immediate Action be submitted to the Governor's Health Care Reform Panel in December 2004, followed by the development of a more comprehensive plan for reform of Louisiana's long-term care system that may reasonably be achieved by 2010 with the resources that are available to the state. The Department of Health and Hospitals (DHH) was designated the lead agency for developing a plan that enhances choice within a long-term care system. The plan is based on national best practices and affords Louisiana residents who are elderly or have disabilities choices from among a broad range of services and supports.

The Program of All-Inclusive Care for the Elderly (PACE) is a service delivery model that began in San Francisco, California in 1973. The model is now established as a permanently recognized organization type under both the Medicare and Medicaid programs. PACE programs offer pre-paid, capitated, comprehensive health care services in a specific geographic area designed to meet the following objectives:

- To enhance the quality of life and autonomy for frail, older adults;
- To maximize the dignity and respect for older adults;
- To enable frail, older adults to live in the community as long as medically and socially feasible; and
- To preserve and support the older adult's family unit.

B. Purpose of RFI

The purpose of this RFI is to elicit responses from organizations interested in partnering with the Centers for Medicare and Medicaid Services (CMS) and DHH in the development of a PACE program in the Monroe area. The Department intends to investigate the possibility of engaging in a cooperative endeavor at a later date based on responses to this RFI.

C. Invitation to Respond

The Department of Health and Hospitals (DHH), Office of Aging and Adult Services is inviting interested not-for-profit organizations (non-profit status required by CMS) to provide the following operational information:

- Organization's mission, history of serving the frail elderly;
- Demographic analysis indicating need for services;
- Targeted geographical service area;
- Financial package including: financial statements for the previous 3 years and financial projections for the next 5 years, and
- Additional information as outlined in Part II, Section E.

The estimated duration of the application and set up process is an estimated two (2) years prior to any participants being served and capitated payments made to the approved PACE organization. DHH reserves the right to terminate any agreements, contracts or relationship with the organization chosen, if during the process DHH determines that the organization is unable or unwilling to progress in a timely manner towards the implementation of a PACE program.

D.

E. RFI Coordinator

Requests for copies of the RFI must be directed to the RFI coordinator listed below:

Ms. Allison Vuljoin

PACE Program Manager

Office of Aging and Adult Services

Department of Health and Hospitals

Bienville Building

628 North 4th Street, 2nd Floor

PO Box 2031

Baton Rouge, LA 70802

Telephone Number: 225.219.0229

Email Address: Avuljoin@dhh.la.gov

SAMPLE

F. Schedule of Events

DHH reserves the right to deviate from this Schedule of Events. In the event it becomes necessary to revise the RFI for any reason, the Department shall provide addenda and/or supplements to potential respondents on its website: www.dhh.state.la.us/publications.asp)

Schedule of Events	Tentative Schedule
Public Notice of RFI	September 17, 2007
Deadline to submit questions	September 28, 2007
Response to questions posted on website	September 24, 2007
Deadline to Submit Information	October 19, 2007
RFI Review by DHH	October 23, 2007
Request for additional information from applicant(s)	October 30, 2007
Organization Selected/Unsuccessful respondents notified by mail	November 13, 2007
Proceed with chosen Organization	November 19, 2007

II. PROJECT OVERVIEW

A. Overview of PACE

PACE is an innovative model of community-based care that enables elderly individuals who are certified as meeting nursing facility level of care to live as independently as possible. For several years PACE operated throughout the country as CMS demonstration waiver programs. The PACE capitated benefit was authorized by the Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing. Louisiana includes PACE as an optional benefit in the Medicaid program.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses beneficiary needs, develops a plan of care, and monitors delivery of all services (including acute care services as well as nursing facility services, when necessary) within an integrated system for a seamless provision of total care. Typically, PACE organizations provide social and medical services in an adult day health center supplemented by clinical, in-home and other services as needed. Studies have shown that participants in PACE show improved health status and quality of life, lower mortality rates, increased choice in how time is spent, and greater confidence in dealing with life's problems.

The financing model combines payments from Medicare and Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE organizations assume full financial risk for beneficiary care without limits on amount, duration or scope of services.

B. PACE Services

The PACE organization is able to coordinate an array of services to older adults with chronic care needs while allowing elders to maintain independence in the community for as long as possible. The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual participant. Typical services include, but are not limited to:

- Adult day health care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care, (PACE organizations must be licensed as adult day health care organizations);
- Primary medical care provided by a PACE physician familiar with the history, needs and preferences of each beneficiary, all specialty medical care, and all mental health care;
- Interdisciplinary assessment and treatment planning;
- Home health care, personal care, homemaker and chore services;
- Restorative therapies;
- Diagnostic services, including laboratory, x-rays, and other necessary tests and procedures;
- Transportation for medical needs;
- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care;
- Social services;
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, durable medical equipment, and medical supplies;
- Respite care; and
- Emergency room services, acute inpatient hospital and nursing facility care when necessary.

The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization. However, individuals who do not qualify for Medicare or Medicaid can also participate in PACE. Those not qualifying for Medicaid (private pay or those covered under long-term care insurance) would pay an amount equivalent to the Medicaid capitated payment.

C. Eligibility

The Federal PACE regulation establishes basic PACE eligibility requirements. Individuals must meet the following criteria:

- Be at least 55 years old;
- Reside in the service area of the PACE organization;
- Meet the state criteria for nursing facility level of care;
- Be able to live safely in the community.

D. Particular Characteristics of PACE

PACE has distinct characteristics that distinguish it from other programs. Listed below is a summary of those characteristics:

- Development process can (and usually does) take between 18 months and 2 years prior to serving participants and receiving capitated payments for enrolled participants;
- Must be a private or public not-for-profit organization primarily engaged in providing PACE services;
- Potential PACE organizations must have adequate financial capacity to fund program development and start-up costs, including identification of patient capacity and break-even considerations;
- PACE organizations do not file claims; they receive a capitated payment at the beginning of each month from Medicare and/or Medicaid or private pay funds, based on the participant's eligibility;
- Must participate in both Medicaid and Medicare;
- PACE organizations must develop a provider network in order to provide/contract for all required covered services and other services necessary to meet participant needs;
- PACE organizations must develop the extensive interdisciplinary team required by the Federal regulation;
- Organization must have the ability to manage the comprehensive care (including acute and long term) of a complex nursing facility eligible population 365 days a year, 24 hours per day, 7 days per week regardless of setting and is at full financial risk for enrolled participants;
- Program must have adequate reserves or reinsurance to cover potential catastrophic health events;
- Each site is geographically specific and is capped at the number of participants that can be enrolled at that site; and
- Participants/enrollees must use the PACE organization's physician and provider network for all health services.

E. PACE Organization Information Package Requirements

The Federal regulations (42CFR Part 460) describe administrative requirements for PACE. DHH will evaluate potential PACE organizations based on the following:

- ❖ Experience in providing primary, acute and/or long-term care services to the target population, the organization's history and mission, the organization's

commitment to principles consistent with the PACE model, and the depth in leadership possessed by the organization that is necessary to implement PACE successfully;

- ❖ Evidence of the need for PACE in the Monroe area that:
  - identifies the targeted geographical service area,
  - shows evidence of demand for PACE services in the proposed service area (the estimate of PACE eligibles should be sufficient to operate a financially viable program),
  - documents the organization's timeline for development;
- ❖ Identification of potential referral sources for potential enrollees;
- ❖ Assessment of alternative long-term care services available in the community;
- ❖ Financial package which includes:
  - audited financial statements for the prior three (3) years for the sponsoring organization;
  - financial projections for start-up and the first five years of operation of the PACE organization. Include total projection of estimated start-up costs including facility development, staffing, equipment, and projected financial losses through break-even;
  - assurance of adequate financial capacity to fund program development and start-up costs, including an estimate of the number of PACE participants that the organization can serve and break-even consideration. (Typically, start-up costs include capital renovation for a PACE center and substantial operational deficits during the program's initial 18-24 months when enrollment is below break-even census. Historically, PACE organizations have spent $2-4 million during start-up);
- ❖ Assurance that provider network will be developed;
- ❖ Assurance that the Executive (Program) Director position will be staffed with a full-time employee. Assurance that the key positions of Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager experienced in providing care to the target population will be staffed; and,
- ❖ Assurance that the organization will meet all State and Federal requirements for PACE organizations.

F. PACE Organization Process

It may take up to two (2) years to complete the process to become a PACE organization. Organizations should understand the process listed below and will be required to complete many of the following general steps:

- Research the Federal regulations and information available from the National PACE Association to assess the feasibility of becoming a PACE organization;
- Complete a feasibility study;
- Submit a response to the RFI to DHH with additional requested information;

- If selected, prepare and submit a PACE provider application to DHH;
- DHH contacts CMS Central Office to notify them of the possible addition of a PACE site;
- DHH evaluates the organization and approves the application as appropriate;
- DHH submits the formal application to CMS along with the DHH assurance that the entity is considered to be qualified as a PACE organization and is willing to enter into a PACE organization agreement with the entity;
- Within 90 days of formal application, CMS approves, denies or requests additional information;
- Develop a PACE Center compliant with the federal PACE regulations and state requirements;
- Once CMS approves, DHH and CMS enter into a PACE program agreement with the organization;
- The PACE organization contracts with DHH; and
- The PACE organization proceeds to enroll participants.

G. Resources Available to Responding Organizations , DHH Contact Personnel

- CMS website at http://www.cms.hhs.gov/pace/
- National PACE Association at http://www.npaonline.org

Any entity seeking to become a Louisiana PACE organization may contact DHH with questions at:

Ms. Allison Vuljoin

PACE Program Manager

Office of Aging and Adult Services

Department of Health and Hospitals

Bienville Building

628 North 4th Street, 2nd Floor

PO Box 2031

Baton Rouge, LA 70802

Telephone: 225.219.0229

Email Address: Avuljoin@dhh.la.gov

II. RESPONSES

A. Response Preparation

The RFI response must describe the background and capabilities of the responding organization. Respondents are asked to submit information according to the order it is presented in Part II, Section E. There is no intent to limit the content of the Information; respondents may include any additional pertinent information.

B. Submission of Information

Respondents should submit one (1) original and three (3) copies of informational packets along with an electronic copy to:

Hugh Eley

Department of Health and Hospitals

Office of Aging and Adult Services

Bienville Building

628 North 4th Street, 2nd Floor

PO Box 2031

Baton Rouge, LA 70802

heley@dhh.la.gov

C. Selection Notices

Each respondent will receive written notification whether the respondent was selected to proceed with the PACE development process. Notices will be mailed by November 13, 2007. DHH reserves the right to reject all responses.